Art Work Dental Dr. Brian Work, DMD

Blending technology & artistry to create beautiful smiles.

Health History Form

(Please Print)

Patient Name: _____ Date: ____/____/____

What has brought you to our office? _____

Are you happy with your smile? (If no, what would you change?)

_____

_____

Do you have any fear of having dental treatment done? _____

Have you ever received nitrous oxide (laughing gas or sedation in a dental office? ☐ No ☐ Yes

Date of your last health care exam: ____/____/____ What was this exam for? _____

Have you been hospitalized in the last 5 years ☐ No ☐ Yes

If yes, What was the reason? _____

Are you currently seeking care? ☐ No ☐ Yes Nature of Care: _____

Please list all physicians who are currently providing you care:

Dr. Name: _____ Phone #: ( )_____

Dr. Name: _____ Phone #: ( )_____

Dr. Name: _____ Phone #: ( )_____

Have you ever been diagnosed or treated for any of the following conditions?

Heart Murmur (mitral valve prolapse)	☐ No ☐ Yes	Psychosis	☐ No ☐ Yes
Anemia	☐ No ☐ Yes	Sore/Enlarged Lymph Nodes	☐ No ☐ Yes
Diabetes	☐ No ☐ Yes	Previous Biopsies	☐ No ☐ Yes
Epilepsy	☐ No ☐ Yes	Slow-Healing Mouth Sores	☐ No ☐ Yes
Hepatitis, Any Form	☐ No ☐ Yes	Other Infections	☐ No ☐ Yes
Rheumatic Fever	☐ No ☐ Yes	Recurrent Illnesses	☐ No ☐ Yes
Asthma	☐ No ☐ Yes	Joint Replacement	☐ No ☐ Yes
Sinus Problems	☐ No ☐ Yes	Glaucoma	☐ No ☐ Yes
Emphysema /other Respiratory Illnesses	☐ No ☐ Yes	Abnormal Bleeding from a cut	☐ No ☐ Yes
Abnormal Heart Condition	☐ No ☐ Yes	Liver Disease (including Jaundice)	☐ No ☐ Yes
Kidney Disease	☐ No ☐ Yes	Unintentional Weight Loss/Gain	☐ No ☐ Yes
Heart (Surgery, Disease, Attack)	☐ No ☐ Yes	Latex Sensitivity	☐ No ☐ Yes
Venereal Disease	☐ No ☐ Yes	H.I.V. Infection/AIDS	☐ No ☐ Yes
Colitis	☐ No ☐ Yes	Abnormal Blood Pressure	☐ No ☐ Yes
Stroke	☐ No ☐ Yes	Migraines	☐ No ☐ Yes
Ulcers	☐ No ☐ Yes		

Any other medical conditions? _____

Do you consume grapefruit juice or grapefruit extract? ☐ No ☐ Yes

Do you require pre-medication with an antibiotic before dental treatment? ☐ No ☐ Yes

Have you been treated with Bisphosphonate drugs? ☐ No ☐ Yes

Are you taking Tagamet (Cimetidine) and Antacids? ☐ No ☐ Yes If yes, how often? _____

Are you allergic or have you had a reaction to:

Local anesthetics	☐ No ☐ Yes	Penicillin or other antibiotics	☐ No ☐ Yes
Aspirin	☐ No ☐ Yes	Codeine, valium or other sedatives	☐ No ☐ Yes

Please List all Allergies or Reactions to Medications or Food: _____

_____

Please Initial _____

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Please List Current Medications Including Herbal Supplements and Vitamins

Medication	Treating Condition	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date

Women:

Are you pregnant? ☐ No ☐ Yes

If no, are you planning a pregnancy in the near future? ☐ No ☐ Yes

Are you a nursing mother? ☐ No ☐ Yes

Are you taking birth control pills? ☐ No ☐ Yes

Are you a smoker? ☐ No ☐ Yes If so, how many cigarettes per day? _____

Weight: _____

Diet:

Restricted Diet: _____

How many meals per day? _____

Food Allergies: _____

Amount of sugar in your diet: ☐ None ☐Slight ☐Moderate ☐High

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of change in my health and medication.

Patient (Print Name)	Patient / Guardian's Signature	/ / Date
Doctor (Print Name)	Doctor's Signature	/ / Date